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Bibliography #22

Outreach to Persons Who Are Homeless

November 2001

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2001

Morris DW, Warnock JK. **Effectiveness of a Mobile Outreach and Crisis Services unit in reducing psychiatric symptoms in a population of homeless persons with severe mental illness.** J Okla State Med Assoc. 94(8):343-6, Aug 2001.

The purpose of this study was to use a time-lag design to evaluate the effectiveness of a Mobile Outreach and Crisis Services unit in remitting psychiatric symptomatology, improving global functioning, and decreasing homelessness in a population of homeless, severely mentally ill residing in a mid-sized urban center. Using a time-lag study design, two groups of subjects--25 individuals before receiving services (control group) and 25 individuals after receiving services (experimental group)--were contrasted across outcome measures. The results indicate that a MOCS unit utilizing a Program for Assertive Community Treatment mode was effective in significantly decreasing psychiatric symptomatology, reducing homelessness, and increasing global functioning. If carefully implemented and interpreted, a time-lag design may be a means of providing valuable feedback and information in a timely manner.

1999

Able-Peterson T; Bucy J. **The streetwork outreach training manual**. Washington, DC: U.S. Department of Health and Human Services, 1993.

This manual is a guide for people concerned about the youths who live on the streets. It describes some of the activities, knowledge, and skills an outreach program needs to provide services to these youth. AVAILABLE FROM: CASSP Technical Assistance Ctr., Georgetown Univ. Child Development Center, 3800 Reservoir Rd., NW, CG-52 Bles, Pediatrics, Washington, DC 20007, (202) 687-8635. COST: $7.00

Clatts MC; Davis WR. **A demographic and behavioral profile of homeless youth in New York City: implications for AIDS outreach and prevention**. Med Anthropol Q, 13(3):365-74, September 1999.

Rapid changes in the world market economy have served to destabilize many local institutions, widening the gap between the rich and the poor and undermining viability of key social and economic institutions such as family and household. Among the most deeply affected by this displacement are children and adolescents, many of whom are forced to leave family institutions before they have acquired the skills and maturity to become economically self-sufficient. Fending for themselves, these youths are at exceptional risk for a wide range of poor health outcomes and premature death. While perhaps a familiar sight in many non-Western countries, this phenomenon also has emerged in the industrialized world, a fact that accounts for the rise in exposure to violence and disease among street-involved youth and young adults in nations such as the U.S. There are few empirical data available about the nature of these populations or the constellation of behaviors that place them at increased risk for disease outcomes. In this report we construct a demographic and behavioral profile of the homeless youth population in NYC, particularly as behavioral patterns relate to risk associated with HIV infection.

Fisk D; Rakfeldt J; Heffernan K; Rowe M. **Outreach workers' experiences in a homeless outreach project: issues of boundaries, ethics and staff safety.** Psychiatr Q, 70(3):231-46, Fall 1999.

Mental health professionals and researchers have emphasized the importance of conducting outreach to locate homeless persons with mental illness, and of creatively engaging these persons into a therapeutic relationship. These outreach and engagement activities raise challenging issues in the areas of client-staff boundaries, professional ethics, and staff safety. While several issues in each of these three key areas have received attention in the growing literature on homelessness, certain issues within each area remain unexplored. The authors draw from the street experiences of outreach staff in a federally funded homeless outreach project to further explore each of these areas, and suggest that experiences of outreach workers are essential in shaping and redefining work activities in these, and other important areas.

Rowe M. **Crossing the border: encounters between homeless people and outreach workers.** Berkeley, CA: University of California Press, 1999.

The relationship between the homeless and the social service community marks a border where the disenfranchised meet the mainstream of society. This book uses ethnographic tools to examine encounters at this border. The author's encounters with the homeless as Director of the New Haven ACCESS outreach project, his interviews with 50 homeless persons for this study, and his interviews with outreach staff, provide a personal perspective. The author draws a collective portrait of the homeless whom he interviewed and observed, discusses the outreach workers in depth, examines transactions from the perspective of each party, and places these encounters within the social and institutional contexts that shape them. AVAILABLE FROM: Univ. of California Press, (800) 822-6657. (COST: $17.95)

Tsemberis S; Elfenbein C. **A perspective on voluntary and involuntary outreach services for the homeless mentally ill.** New Dir Ment Health Serv, (82):9-19, Summer 1999.

Outreach teams use a range of strategies to engage people who are homeless and mentally ill and living on the streets. This chapter describes and evaluates the effectiveness of various voluntary and involuntary approaches and presents a new model program for serving this population.

1998

Curtis JL; Millman EJ; Struening EL; D'Ercole A. **Does outreach case management improve patients' quality of life?** Psychiatric Services, 49(3): 351-354, 1998.

This article examined whether enhancing standard aftercare with an outreach case management intervention would improve patients' quality of life. A sample of 292 patients discharged from an inpatient psychiatry service were assigned to either an intervention group that received case management or a control group that received standard aftercare services. Interviews were conducted during the follow-up period, which lasted 15 to 52 months, to determine quality of life in 39 different categories. No difference was found between the groups on any of the quality of life variables. The authors conclude that outreach case management was not associated with improved quality of life.

Dixon L; Stewart B; Krauss N; Robbins J; Hackman A; Lehman A. **The participation of families of homeless persons with severe mental illness in an outreach intervention.** Community Mental Health Journal, 34(3): 251-259, 1998.

This article describes how an assertive community treatment (ACT) team that employs a family outreach worker interacts with homeless persons with severe mental illness. The team's ratings of the frequency and the importance of clients' and treatment team's family contact are summarized and compared with independent research reports on patients' satisfaction with family relations, housing, and hospitalization outcomes. 73% of clients had contact with their families, and ACT worked with 61% of these families. Findings showed that client days in stable housing were associated with increased ACT family contact.

Erickson S; Page J. **To dance with grace: outreach and engagement to persons on the street.** Washington, DC: Presented at the Department of Health and Human Services Workshop on Exemplary Practices Addressing Homelessness and Health Care Issues, 1998.

This paper provides definitions, exemplary practice models, and an extensive bibliography for further inquiry into the topics of outreach and engagement for people who are homeless. Outreach is defined as the initial and most critical step in connecting or reconnecting a homeless individual to needed services, and engagement is described as the process by which a trusting relationship between worker and client is established. The authors also discuss the specific needs of homeless populations, values and principles of outreach, and characteristics of outreach workers. A number of different outreach approaches are described.

Gerber JC; Stewart DL. **Prevention and control of hypertension and diabetes in an underserved population through community outreach and disease management: a plan of action.** J Assoc Acad Minor Phys, 9(3):48-52, 1998.

Hypertension and diabetes are overrepresented in the African-American population and can be particularly devastating in this population. These diseases share genetic predisposition, medical risk factors, and environmental influences as etiologic factors, and they may be interrelated, at least in part, by obesity and accompanying hyperinsulinemia. Noncompliance with treatment plans is a significant barrier to health improvement in both diseases, but increased attention to patient involvement in care is a potential solution to this long-standing problem. The Baltimore Alliance for the Prevention and Control of Hypertension and Diabetes was established in January 1998 to promote care to the underserved community of West Baltimore, Maryland, and to improve outcomes of hypertension and diabetes. Based at the University of Maryland School of Medicine, the Baltimore Alliance comprises a community health worker program, a church-based education and screening effort, managed care and pharmaceutical company (Hoechst Marion Roussel) partners, a health policy and services research group, and inpatient/outpatient clinical care sites in the health system. Mobilization, cultural relevance, and partnership are employed to ensure that the Alliance's goals of increased patient enrollment and retention in treatment programs will be achieved. Thereby, improved outcomes--clinical, humanistic, and economic--will result. Novel as well as classic approaches to patient education, compliance, and goal achievement are being pursued. Complete expert systems for hypertension and diabetes disease management are being created and will be implemented in the near future. Baseline practices and current outcomes are being identified to act as historical controls. The organization and administration of the Alliance will serve as a prototype that others may follow.

Lam JA; Rosenheck R. **Street outreach for homeless persons with serious mental illness: is it effective?** Rockville, MD: Center for Mental Health Services, 1998. (DRAFT- Unpublished Paper)

This study examined data on case management clients who are homeless and have a severe mental illness to determine how those contacted through street outreach differ in their socio-demographic characteristics, service needs, and outcomes from those clients contacted in shelters and other health and social service agencies. As part of the Center for Mental Health Services' Access to Community Care and Effective Services and Supports (ACCESS) program, data were obtained from potential clients over the first three years of the program at the time of the first outreach contact (n=11,857), at the time of enrollment in the case management program (n=5,431), and three months after enrollment (n=4,587). Clients contacted at outreach on the street were more likely to be male, older, spent more night literally homeless, were more likely to have psychotic disorders, and took longer to engage in case management. Three month outcome data showed that enrolled clients contacted through street outreach showed improvement equivalent to those enrolled clients contacted in shelters and other service agencies. The authors conclude that street outreach appears to be effective as the clients reached in this way showed improvement equal to that of other clients in most outcome domains.

Levy JS. **Homeless outreach: a developmental model.** Psychiatric Rehabilitation Journal 22(2): 123-131, 1998.

In this article, the author introduces an outreach model based on universal principles of ecology and development in order to better serve disaffiliated, homeless adults with psychiatric disabilities. The outreach process is viewed as transactional in nature and consisting of manageable stages. This presents a transactional and phasic context for a psychosocial developmental assessment which identifies client-worker issues relevant to each phase of the management process. This model provides outreach counselors with guidance toward establishing the critical helping relationship needed for homeless persons with psychiatric disabilities to transition to a home in the community.

McCarley TD; Yates WR. **Mobile Outreach Crisis Services (MOCS): an innovative model for taking psychiatric care into the community.** J Okla State Med Assoc, 91(8):452-6, November 1998.

Mobile outreach psychiatric services have become a popular model of providing care to the mentally ill. A mobile program has been instituted in Tulsa, Oklahoma, to provide care to homeless mentally ill in Tulsa County and to assist with emergency crisis intervention. The SPMI (Severely and Persistently Mentally III) have been a challenge for both medical and psychiatric providers, and MOCS (Mobile Outreach Crisis Services) was developed to address these problems. This article describes MOCS, briefly reviews recent literature, and discusses ways this program can benefit primary care physicians.

National Network for Youth. **Toolkit for youth workers: street outreach.** Washington, DC: National Network for Youth, 1998.

This bibliography lists resources covering street outreach to homeless youth and other street populations. AVAILABLE FROM: National Network for Youth, 1319 F Street, NW, Suite 401, Washington DC 20004, (202) 783-7949.

Wasmer D. **Engagement of persons who are homeless and have serious mental illness: an overview of the literature and review of practices by eight successful programs.** Chicago, IL: De Paul University, 1998.

This paper examines the literature on outreach to persons who are homeless and have serious mental illness and the results of a survey of eight programs that offer outreach services. Programs were found to share a highly mobile "find and serve" approach to the target population. The largest portion of new clients are engaged at homeless shelters, followed by mobile outreach to other homeless service sites. Outreach to streets and public places is maintained by most programs and special drop-in centers for the target group are operated by others. Offering help with basic needs, especially emergent health problems, was found to be a critical ingredient to linkage and committed staff make things happen despite myriad challenges. Continued investigation into the features of successful outreach, especially the amount and duration of linkage efforts and details about the timing of basic needs and supports, would help advance the principles of what is a distinct component of today's mental health service system.

1997

Cousineau MR. **Health status of and access to health services by residents of urban encampments in Los Angeles.** J Health Care Poor Underserved, 8(1): 70-82, February 1997.

This paper reports findings from a survey of 134 homeless people living in 42 urban encampments in central Los Angeles. These data, of concern to public health officials, include the physical conditions in the camps, the health status of residents, their use of drugs and alcohol, and their access to and use of health care services such as substance abuse treatment. Many encampment residents report poor health status; over 30% report chronic illnesses, and 40% report a substance abuse problem. Although outreach efforts have had success in bringing HIV and tuberculosis screening services to encampments, residents report significant barriers to using primary health care and drug and alcohol treatment services. Public hospitals and clinics remain the major source of primary medical care for homeless people living in encampments. Outreach and case management continue to be critical components of improved access to health care for homeless people.

Goering P; Wasylenki D; Lindsay S; Lemire D; Rhodes A. **Process and outcome in a hostel outreach program for homeless clients with severe mental illness.** American Journal of Orthopsychiatry, 67(4): 607-617, 1997.

This article reports on findings of an 18-month follow-up of 55 homeless and severely mentally ill clients of a hostel outreach program. Results indicated that despite chronic histories of transiency and shelter use, housing stability had been achieved. Initial gains in social functioning and symptom reduction also increased. The authors contend that development of a strong working alliance between clients and their case managers proved to be a key element in the results.

Jones A; Scannell T. **Outreach interventions for the homeless mentally ill.** Br J Nurs, 6(21):1236-8, 1240-3, Nov 27-Dec 10, 1997.

There has been a steady rise in the number of homeless mentally ill in Britain. This article reviews the scale of the problem and identifies the need for change within mental health services in order to address this challenge. It is argued that mainstream psychiatric services need to become more diverse and open in their approach to this potentially isolated group of users. The authors suggest that this could be achieved by embracing assertive outreach interventions. Innovative projects using a range of care providers, including voluntary workers, past users of the service and professional mental health workers, are discussed as an alternative framework to traditional services. In conclusion, the article highlights some of the professional and social implications for psychiatric nurses and mental health practice.

Knight EL. **A model of the dissemination of self-help in public mental health systems.** New Directions for Mental Health Services, 74: 43-51, 1997.

This article discusses the origins of self-help and begins by providing an understanding of four forms of self-help: mutual support, advocacy, consumer/survivor run services, and coping. The author then looks at examples of the five different strategies by which self-help in public mental health systems has been disseminated. These strategies include: intensive strategies that show the efficacy of the model, extensive strategies of outreach to as many people as possible, and the process of legitimation through research and development, symbolic dissemination, and flanking strategies.

Martin E; McDaniels C; Crespo J; Lanier D. **Delivering health information services and technologies to urban community health centers: the Chicago AIDS Outreach Project**. Bull Med Libr Assoc, 85(4): 356-61. October 1997.

Health professionals cannot address public health issues effectively unless they have immediate access to current biomedical information. This paper reports on one mode of access, the Chicago AIDS Outreach Project, which was supported by the National Library of Medicine through outreach awards in 1995 and 1996. The three-year project is an effort to link the programs and services of the University of Illinois at Chicago Library of the Health Sciences and the Midwest AIDS Training and Education Center with the clinic services of community-based organizations in Chicago. The project was designed to provide electronic access to AIDS-related information for AIDS patients, the affected community, and their care givers. The project also provided Internet access and training and continued access to library resources. The successful initiative suggests a working model for outreach to health professionals in an urban setting.

McElmurry BJ; Wansley R; Gugenheim AM; Gombe S; Dublin P. **The Chicago Health Corps: strengthening communities through structured volunteer service.** Adv Pract Nurs Q, 2(4):59-66, Spring 1997.

The Chicago Health Corps is an AmeriCorps*USA program, established in 1994 by the Corporation for National Service in partnership with the Health Resources and Services Administration (HRSA) of the U.S. Public Health Service. The Chicago Health Corps deploys 20 full-time equivalent corps members in selected community sites that offer primary health care services to Chicago's underserved families. Chicago Health Corps members provide a combination of outreach, home visit, and case management

services to address unmet health needs identified by community members, including both laypersons and professionals. Providing meaningful opportunities for participants to assist their communities with health care helps corps members develop an awareness of their fellow community members and an ethic of service.

Plescia M; Watts R; Neibacher S; Strelnick H. **A multidisciplinary health care outreach team to the homeless: the 10-year experience of the Montefiore Care for the Homeless Team."** Family and Community Health, 20(2): 58-69, 1997.

This article describes efforts by the Montefiore Care for the Homeless Team, a multidisciplinary health care outreach team that has provided health care to a diverse homeless population in the Bronx, N.Y. for 10 years. Yearly descriptions of patient demographics, continuity measures, diagnoses, interventions, and referral patterns are presented for a four-year period. These reveal that an increasing number and diversity of services have been provided by nurse practitioners who address social problems and preventive care in addition to providing direct clinical care for a range of acute and chronic health problems. Findings also indicate that providing services at on-site premises led to the building of relationships with shelter and soup kitchen staff, and improved patient participation and social support. The authors suggest that a multidisciplinary team approach reduces barriers to health care services for the homeless populations and contributes to improved provider retention.

Porter B. **To reach the homeless.** New York, NY: Times Square Business Improvement District, 1997.

This report describes the first year of a major effort to address homelessness in the Times Square district in New York City. The stories demonstrate the difficulty of the work and challenge the reader to continue to grapple with the complexities involved in working with homeless clients. Components of the project described include: concept; challenges; outreach; stories about specific people who are homeless; and results of the program after one year. The author concludes that outreach teams will reduce the number of homeless people in Times Square as first year results indicate that some people who are homeless do accept offers of help and come inside.

Shalala D. **Recognizing community outreach nurses**. Nurs Manage, 28(8):64, August 1997.

In an address to the nurses at Pine Street Inn Nurses' Clinics in Boston, Massachusetts, U.S. Secretary of Health and Human Services Donna Shalala recognizes their commitment to outreach and preventive care for homeless men and women. For the past 25 years, the clinic-the first in the country to be licensed by a state-has been caring for citizens who too often fall through the cracks of the health care system.

1996

Aiemagno SA; Cochran D; Feucht TE; Stephens RC; Butts JM; Wolfe SA. **Assessing substance abuse treatment needs among the homeless: a telephone-based interactive voice response system**. Am J Public Health, 86:1626-8, November 1996.

OBJECTIVES: We report on a pilot project that used a telephone-based interactive voice response system accessed by cellular phones at diverse sites, to interview homeless persons on their need for alcohol and other drug treatment. METHODS: Using this technique we surveyed 207 homeless adults at eight shelters in Cleveland, Ohio. RESULTS: The cellular approach was comparable to human-administered interviews in reliability and validity and yielded higher self-reported levels of drug use. CONCLUSIONS: Cellular telephones and interactive voice response interviewing systems can be useful tools in assessing for the health-service needs of difficult-to-reach populations.

Alexy B; Elnitsky C. **Community outreach: rural mobile health unit**. Journal of Nursing Administration, 26(12): 38-42, 1996.

With the increased emphasis on cost containment, hospital administrators are investigating community outreach projects to remain economically viable. The authors describe the planning and implementation of a mobile health unit for rural elderly residents. This project represents an alternative model of healthcare delivery in a rural area with limited resources and healthcare providers.

Buhrich N; Teesson M. **Impact of a psychiatric outreach service for homeless persons with schizophrenia.** Psychiatr Serv, 47(6): 644-646, June 1996.

Since 1988, a 24-hour psychiatric outreach service has been in operation in the inner city of Sydney to provide services to residents of refuges for the homeless. A total of 506 homeless persons with schizophrenia were referred to the outreach service between April 1988 and mid-1992, of whom 91 failed to attend. Hospitalization data were collected for the four years before and the four years after each individual's referral to the service. After the introduction of the service, the rate and duration of psychiatric hospital admissions for residents with schizophrenia who were treated by the outreach service decreased significantly, whereas those who failed to attend showed no such decrease.

Fuhr ME. **No place to stay: a handbook for homeless outreach.** Oakland, CA: M. Elizabeth Fuhr, 1996.

Based on her six years experience of providing outreach to elderly homeless persons in Oakland, Calif., the author offers this guide to outreach and engagement. Topics covered include: (1) an overview of case management; (2) skill building exercises; (3) personal stories, poetry, and art by homeless persons; (4) specific needs of the homeless person with alcohol and drug addiction and/or mental disorders; and (5) concerns of the older homeless person. AVAILABLE FROM: M. Elizabeth Fuhr, PO Box 7159, Oakland, CA, 94601.

Lope M. **The perils of outreach work: overreaching the limits of persuasive tactics.** In Dennis D; Monahan J(eds.), *Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law*, 85-92. Plenum Publishing Corporation, 1996.

This chapter discusses some of the engagement strategies used by outreach workers that could be considered coercive. According to the author, the outreach worker, whose primary mission is to canvass the streets looking for persons with mental illnesses in need of medication, treatment or homes, must invent strategies that engage the prospective client into treatment, even though that client has fled from mental health workers in the past. To identify whether the tactics of the outreach worker are coercive, one must acknowledge that the outreach worker is in a position of power when she or he relates to a client.

McQuistion HL; D'Ercole A; Kopelson E. **Urban street outreach: using clinical principles to steer the system.** New Directions for Mental Health Services, 52 (Winter): 17-27, 1996.

The authors explain that a decade ago, urban street outreach was part of a rapid response to the epidemic of homelessness, but today it struggles to develop into a clinical craft that will define its own niche in the system of services to homeless people who have mental illnesses. A study was conducted to begin to understand the process and the outcome of urban street outreach, as the engagement and referral activity of a well-established outreach service was examined. The authors contend that program planning needs to establish a structure in which sound clinical principles can flourish.

Morse GA; Calsyn RJ; Miller J; Rosenberg P; West L; Gilliland J. **Outreach to homeless mentally ill people: conceptual and clinical considerations**. Community Ment Health J, 32:261-74, June 1996.

This paper describes a model of outreach predicated on developing a trusting, meaningful relationship between outreach workers and homeless persons with mental illness. Five common tasks inherent in this model of outreach are establishing contact and credibility, identifying people with mental illness, engaging clients, conducting assessments and treatment planning, and providing ongoing service. Other issues include: (1) Responding to dependency needs and promoting autonomy; (2) setting limits while maintaining flexibility; and (3) resistance to mental health treatment and follow-up service options.

Testani-Dufour L; Green L; Green R; Carter KF. **Establishing outreach health services for homeless persons: an emerging role for nurse managers**. J Community Health Nurs, 13(4): 221-235, 1996.

Nurse-managed clinics can be an effective strategy for addressing the health care needs of homeless and indigent populations. The role of the nurse manager in the establishment of a clinic involves community leadership--specifically, it involves addressing strategic planning, financial and manpower issues. The collaborative relationship of nurse managers, educators, and the community laid the groundwork for accessible and affordable health care for the homeless and indigent of one northwest Georgia community. Specific tools and strategies are presented.

1995

American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, National Alliance for the Mentally Ill, National Depressive and Manic-Depressive Association, National Mental Health Association, National Institute of Mental Health. **Idea & information exchange for 1995. reaching underserved populations.** Washington, DC: American Psychiatric Association, January, 1995.

This booklet provides tips and ideas for planning successful community outreach programs, a guide of events and campaigns in 1995, information on program resources and materials, and camera-ready art. It includes articles which feature stories and materials geared for special audiences such as African Americans, Asian Americans, children and adolescents, the elderly, gays an lesbians, Hispanics, and women. AVAILABLE FROM: American Psychiatric Association, Division of Public Affairs, 1400 K Street, NW, Washington, DC 20005, (202) 682-6324.

Bybee D; Mowbray CT; Cohen EH. **Evaluation of a homeless mentally ill outreach program: differential short-term effects.** Evaluation and Program Planning 18(1):13-24, 1995.

Previously published research on interventions for homeless persons who have mental illnesses has exhibited marked limitations in attrition, sample sizes, generalizability and outcome measures. This report presents results from an outreach and linkage project wherein the research design concentrates on addressing these limitations. Successful outcomes in terms of the number housed were documented. However, significant changes in participant functioning levels were not. Three variables were significant predictors of residential stability at four months: recruitment source (shelter, psychiatric hospital or community mental health agency); client functioning; and hours of service from the homeless project. The latter finding suggests that project interventions contributed to positive changes in clients' residences. Implications of the results for future service and research efforts are discussed.

Clatts MC; Davis WR; Atillasoy A. **Hitting a moving target: the use of ethnographic methods in the development of sampling strategies for the evaluation of AIDS outreach programs for homeless youth in New York City**. NIDA Res Monogr, 157:117-35, 1995.

Cunnane E, Wyman W, Rotermund A, Murray R. **Innovative programming in a community service center**. Community Ment Health J, 31(2): 153-161, April 1995.

A Community Center in a downtown urban area offers comprehensive services that provide continuity and choice to homeless and poor people. Emphasis is on outreach, through a Day Treatment Program for severely, persistently mentally ill homeless, a mobile outreach team, and neighborhood services, and/or employment, including a restaurant and Employment Reintegration Program. The Center is an example of how professionals, community and business leaders, and citizens can unite to assist clients and how programs can evolve from clients' requests and participation in services. The Center's programming can be followed in any community in this health care reform era.

1994

Anchorage Community Mental Health Services. **Crossover House homeless project: an outreach intervention for homeless adults experiencing severe mental illness and substance use disorders.** Anchorage, AK: Anchorage Community Mental Health Services, 1994.

This document contains information focusing upon an approach to serving individuals who are homeless and experiencing dual-diagnosis conditions in the earliest phase of service delivery. A conceptual framework is provided to describe the Crossover House's outreach intervention model. Other topics discussed include: the history and setting of intervention; a literature review; client population; program structure; outreach intervention; specific case studies; lessons learned; and recommendations from the authors. AVAILABLE FROM: South Central Counseling Center, Crossover House, 1000 E. 4th Ave., Anchorage, AK 99501.

Barry M; Fleck E; Lentz S; Bell C; O'Connor P; Horwitz R. **"Medicine on wheels": an opportunity for outreach and house staff education**. Conn Med, 58(9): 535-539, September 1994.

Ambulatory-care teaching programs have been traditionally based in hospital settings. As many patients, in particular the homeless and underinsured, have never reached these settings, we describe a nontraditional outreach health care program for medical residents. This multidisciplinary program places medical residents on a mobile van to deliver care to a population in New Haven where 18.2% of its families are below the poverty level and have limited or no access to health care at the teaching hospital. On-site urgent care is given along with HIV, pregnancy testing, and blood pressure screening. Health care follow-up, dental care, alcohol detoxification, and drug counseling are scheduled. A total of 764 adult patients were seen between November 1991 and June 1993 by PGY2 residents on ambulatory rotations. One hundred forty-one patients consented to respond to a questionnaire. Thirty-seven (26%) were homeless with a mean length of homelessness of 15 months. Forty-one percent had been victimized within one year and 33% currently used illicit drugs. The benefits of this unique ambulatory teaching program for medical residents are described.

Bybee D; Mowbray CT; Cohen E. **Short versus longer term effectiveness of an outreach program for the homeless mentally ill**. Am J Community Psychol, 22:181-209, April 1994.

Presents 12-month results from an outreach/linkage intervention with persons who are homeless and mentally ill, comparing these with results obtained at four months. Both sets reflect the success of the program in placing individuals in independent housing. However, longer term data provide information regarding client movement patterns and increased tenure in nonhomeless living arrangements beyond the termination of specialized services. Analyses of 12-month residential outcomes identified four variables as significant predictors: recruitment source, project service duration, CMH service duration, and client age. In contrast to four-month predictors, variables reflecting baseline client functioning were no longer significantly related to outcome, suggesting that the positive effects of the intervention may take longer to achieve with some clients. Discussion focuses on the implications of these effectiveness results for future research designs and measures and the utility and limitations of pre-experimental approaches for evaluating innovative service models when implementation and efficacy experiences are lacking.

Nyamathi AM; Flaskerud J; Bennett C; Leake B; Lewis C. **Evaluation of two AIDS education programs for impoverished Latina women.** AIDS Educ Prev, 6(4):296-309, August 1994.

This paper evaluates the effectiveness of two culturally sensitive AIDS education programs developed by the UCLA AIDS Nursing Network and delivered to 213 impoverished Latina homeless or drug-addicted women in Los Angeles. The Comprehensive Health Seeking and Coping Paradigm guided the program, which was implemented by specially trained Latina nurses and outreach workers. A quasi-experimental design was used where women were randomized by site into specialized (n=82) and traditional (n=131) programs. Two-week posttest analyses were conducted to assess program effectiveness and selected demographic characteristics, including acculturation. Results indicated that women in both AIDS education programs improved significantly in cognitive, behavioral, and psychologic outcomes.

Slagg NB; Lyons JS; Cook JA; Wasmer DJ; Ruth A. **A profile of clients served by a mobile outreach program for homeless mentally ill persons.** Hospital and Comm. Psychiaty 45(11):1139-1141, 1994.

According to the authors, mobile outreach and crisis services, which have proven effective for persons with mental illnesses have also proven effective for homeless persons, with mental illnesses' but are not sufficiently available. This article describes the services offered and the population served by a mobile assessment program in its first 24 months of operation. The mobile assessment program was established in 1990 by Thresholds and serves a catchment area encompassing urban Chicago, Ill.

1993

DiBlasio FA; Belcher JR. **Social work outreach to homeless people and the need to address issues of self-esteem.** Health Soc Work, 18(4):281-7, November 1993.

This article assesses self-esteem in a sample of homeless people from a major urban area. The findings indicate bivariate associations between low self-esteem and depression, family relationships, goal attainment, disability, health, and food deprivation. Multivariate analysis suggests that depression and poor health are the two most significant variables that contribute to low self-esteem. Social work outreach can provide services to positively influence homeless peoples' lives. First, however, it is important to facilitate proper psychosocial and psychiatric assessment, to make a diagnosis, and to provide on-site treatment.

Illing J; Hulme N; Gibson B; Minchom D; Aroney R; Barton S. **Outreach work targeting young men who sell sex: accessing a "difficult to reach group" into sexual health care**. Int Conf AIDS, 9:701 (abstract no. PO-C14-2906), June 6-11, 1993

OBJECTIVES: To evaluate, after one year, a project where by a Health Advisor from a central London clinic for sexually transmitted diseases was available at a drop-in center in central London for young men who sell sex on the street. METHODS: A Health Advisor attended a drop-in center on a weekly basis for a two-hour session. The attenders at the center were young men who sold sex and had been identified as a "hard to reach group." The time was spent on sexual health education and trying to break down barriers of suspicion of authority and to build trust in order to access these male prostitutes into mainstream medical

care. After a 12-month period the medical records of those patients identified as attending the clinic as a direct result of this intervention were reviewed. RESULTS: Tabular data, see abstract volume. CONCLUSION: This intervention proved effective in targeting education and accessing into sexual health care a vulnerable and difficult to reach group. Cost analysis has shown the project to be a justifiable use of resources and could be a useful model.

Kasper MJ; Robbins L; Root L; Peterson MG; Allegrante JP. **A musculoskeletal outreach screening, treatment, and education program for urban minority children.** Arthritis Care Res, 6(3):126-33, September 1993.

PURPOSE. A hospital-based outreach program was initiated to screen minority children in medically underserved areas of New York City for musculoskeletal diseases. We examine the number of such diseases in this population, and evaluate the program's success to facilitate referral and follow-up of children with referral conditions. METHODS. Screenings were conducted at schools and day-care centers. Children requiring further evaluation were referred to the sponsoring hospital, a major referral center for musculoskeletal diseases. Bilingual educational strategies, transportation reimbursement, and coverage for uninsured children were used to foster participation and increase follow-up. RESULTS. A total of 2,523 children were screened, 168 (6.7%) of whom were referred for one of 45 different musculoskeletal disorders, including scoliosis and back problems, foot problems, in- and out-toeing, knee or hip pain, and problems of joint range of motion. Sixty-seven percent of those referred had a follow-up medical consultation. CONCLUSIONS. A substantial proportion of urban minority children have previously undiagnosed musculoskeletal disorders that, if left untreated, have the potential to lead to significant disability in later life. Targeted screening programs can be effective in identifying such disorders, and providing and opportunity for early diagnosis, treatment, and education.

Plotkin MR; Narr,OA. **The police response to the homeless: a status report.** Washington, DC: Police Executive Research Forum, 1993.

This report presents the findings of a comprehensive study of the police response to street people. Conducted by the Police Executive Research Forum (PERF), with support from The Robert Wood Johnson Foundation, this study was designed to improve the way in which police interact with street people through increased awareness of the scope of the problem, and through recognition of meaningful, effective responses. According to the report, a number of city police departments around the country have created special units to cope with homelessness. For example, the New York City Transit Police have established outreach teams to reduce homelessness in the city's subway system. The police remove homeless individuals who set up housekeeping in the subway facilities by transporting them to shelters in buses, and by discouraging aggressive panhandling and sleeping on subway benches or seats. Seattle, Washington, Las Vegas and Reno, Nevada, and Santa Monica, California are among the cities that have created special units which deal nearly exclusively with homeless individuals. The authors contend that police officers often serve as social workers to the needy and powerless members of the community, as well as enforcers of the law and keepers of public order (authors). AVAILABLE FROM: Police Executive Research Forum, 2300 M Street, N. W., Suite 910, Washington, DC 20037, (202) 466-7820. (COST: $23.95) (ISBN 1-878734-31-8)

Podschun GD. **Teen peer outreach-street work project: HIV prevention education for runaway and homeless youth**. Public Health Rep, 108:150-5, March-April 1993.

Each year, there are approximately two million homeless and runaway youths in the United States. On any given night, there are 1,000 homeless youngsters living on the streets of San Diego, Calif. Homeless young people are commonly involved in one or more of the following activities that place them at risk for HIV infection--unprotected sexual intercourse, needle-sharing in the use of injectable drugs, sex with someone who injects drugs. The Teen Peer Outreach-Street Work Project trains teen peer educators to work in three existing San Diego youth service programs with street outreach staff members to provide HIV prevention education and referral services to San Diego's homeless youth. Selected teens from the target population also participate in street-based case management that provides skill development to bring about behavioral and attitudinal changes. An HIV outreach program cannot stand alone and is most successful if it is integrated with services that meet the basic needs of its clients. In the three participating youth service programs of the Teen Peer Outreach-Street Work Project, food, clothes, and shelter information are provided. There are shelters in two of the three programs that become places where HIV educational messages, delivered on the street, can be reinforced. Immediate and concrete assistance can be offered to homeless youth. Low literacy among the target population presents a significant obstacle to adequate and appropriate HIV prevention education for homeless youth. Currently, education materials that specifically target homeless youth do not exist. The outreach street project is being expanded to develop materials for homeless youth with low literacy levels.(ABSTRACT TRUNCATED AT 250 WORDS)

Rosenheck R; Gallup P; Frisman LK. **Health care utilization and costs after entry into an outreach program for homeless mentally ill veterans.** Hosp Community Psychiatry, 44(12): 1166-1171, December 1993.

OBJECTIVE: This study evaluated the impact of a Department of Veterans Affairs outreach and residential treatment program for homeless mentally ill veterans on utilization and cost of health care services provided by the V.A. METHODS: Veterans at nine program sites (n=1,748) were assessed with a standard intake instrument. Services provided by the outreach program were documented in quarterly clinical reports and in residential treatment discharge summaries. Data on nonprogram VA health service utilization and health care costs were obtained from national VA data bases. Changes in use of services and cost of services from the year before initial contact with the program to the year after were analyzed. The relationship of these changes to indicators of clinical need and to participation in the outreach program were analyzed. RESULTS: Although utilization of inpatient service did not increase after veterans' initial contact with the program, use of domiciliary and outpatient services increased substantially. Total annual costs to the VA also increased by 35%, from $6,414 to $8,699 per veteran per year. Both clinical need and participation in the program were associated with increased use of health services and increased cost. Veterans with concomitant psychiatric and substance abuse problems used fewer health care services than others. CONCLUSIONS: Specialized programs to improve the access of homeless mentally ill persons to health care services appear to be effective, but costly. Dually diagnosed persons seem especially difficult to engage in treatment.

Wasylenki DA; Goering PN; Lemire D; Lindsey S; Lancee W. **The hostel outreach program: assertive case management for homeless mentally ill persons**. Hosp Community Psych, 44:848-53, September 1993.

OBJECTIVE: This study measured the impact of an assertive case management program for

psychiatrically disabled homeless persons in metropolitan Toronto. It was hypothesized that the program would improve residential stability, reduce psychiatric symptoms, improve social functioning, improve social networks, and increase use of appropriate services. METHOD: For 59 clients, assessments for the nine-month period before program entry were completed and were repeated nine months later. The Brief Psychiatric Rating Scale and a version of the Scale for Level of Functioning were the main outcome measures. RESULTS: At follow-up, significant improvements in residential stability and reductions in psychopathology were demonstrated. Improvements in social functioning and increases in social network size were significant. Although no baseline data about service use were collected, clients used basic support services during their first nine months in the program. CONCLUSIONS: The success of the program demonstrates that a difficult-to-treat patient population can be helped in a humane fashion if trained personnel are available.

1992

Brightman C; LaHoste J. **HIV/AIDS education and outreach services as a point of entry into comprehensive primary health care.** Int Conf AIDS, 8:D509 (abstract no. PoD 5721), July 19-24, 1992.

ISSUE/PROBLEM: Many people with HIV and AIDS or at high risk for HIV infection in the William F. Ryan Community Health Center's service area do not receive comprehensive medical and psychosocial service due to an array of barriers including poverty, lack of insurance, and difficulty accessing existing services. DESCRIPTION OF PROJECT: The Ryan Center's HIV/AIDS Education and Outreach Program provides HIV prevention education and outreach services at target locations in the community: transitional housing facilities for homeless persons, schools, other agencies, bus and subway stations, and in the streets and parks. The Program facilitates target populations' entry into the comprehensive, ambulatory primary health care delivery system of the Ryan Center. RESULTS: Persons who otherwise may not receive health care services gain access to affordable, comprehensive primary health care services in their community, including HIV-related services. LESSONS LEARNED: Community-based primary care providers must make efforts, including providing services off-site in the community, to reach segments of the population least likely to have comprehensive health care and at the highest risk for HIV infection. Community-based providers can serve as a national model for providing low-cost, high-quality services and improving health indicators, including HIV disease, among medically underserved populations.

Cohen NL. **Outreach intervention models for the homeless mentally ill**. In Lamb HR; Bachrach LL; Kass FI (eds.), *Treating the Homeless Mentally Ill*. Washington, DC: American Psychiatric Association, 1992.

One service component that is essential for the maintenance of a comprehensive and integrated system of community care services for the chronically mentally ill - and one that is often missing - is the interdisciplinary mobile crisis intervention and outreach team. This chapter describes the goals and characteristics of outreach intervention models, in particular the Homeless Emergency Liaison Project (HELP), established in New York City in the early 1980s. Project HELP emphasizes outreach with access to hospital treatment through involuntary commitment. Models of outreach intervention need to be tailored to the realities of service system accessibility in the community in order to maintain responsiveness to the individual's needs. Those homeless mentally ill who are the most visible victims of

the era of deinstitutionalization are greatly in need of outreach approaches to connect or reconnect them to community services. The work is labor-intensive and requires a commitment to establishing linkages among a continuum of service providers, especially if the larger service system is fragmented and poorly coordinated.

Cohen CI; Onserud H; Monaco C. **Project Rescue: serving the homeless and marginally housed elderly.** The Gerontologist, 32(4):466-471, 1992.

The aim of this article is to provide an overview of a model program for older homeless persons, focusing on service delivery and outreach techniques. Project Rescue in New York City, a daytime drop-in center, is profiled. The authors provide outcome data and identify client characteristics that predict successful outcomes. The strongest predictors of outcome were number of service encounters, type of presenting problem, and perceived level of social support.

Fredriksen KI. **North of Market: older women's alcohol outreach program**. Gerontologist, 32(2):270-, April 1992.

The North of Market Older Women's Alcohol Program is an innovative outreach program designed to assist isolated and impoverished alcohol-dependent older women. The program utilized service components focused on "building up" the clientele and developing support networks rather than the traditional approach of first "breaking down" an alcoholic's defense barriers. Sobriety (complete abstinence) was attained by 60% of the women for a minimum of 3 months (not necessarily consecutive).

Katz SE; Sabatini A; Codd C. **The Homeless Initiative and Project HELP: historical perspectives and program description.** In Katz SE; Nardacci D; Sabatini A (eds.), *Intensive Treatment of the Homeless Mentally Ill*. Washington, DC: American Psychiatric Press, 1992.

In this chapter, a brief historical background on homelessness and mental illness is presented. The authors describe the key features of the Homeless Initiative program in New York City. Prehospital outreach is provided by mobile crisis intervention teams (Project HELP) that consist of psychiatrists, social workers, and nurses. These teams make an initial psychiatric assessment and can transport clients involuntarily to a municipal hospital for further assessment and admission. The authors discuss the benefits of the program and difficulties it has encountered.

Nasper E; Curry M; Omara-Otunnu E. **Aggressive outreach to homeless mentally ill people**. New England Journal of Public Policy 8(1):715-727, 1992.

The Greater Bridgeport Community Mental Health Center in Connecticut has addressed the need for mental health services for the homeless through the formation of the Homeless Outreach Team (HOT). This article describes the development, organization, clinical work, and future of HOT. Team members identify homeless mentally ill persons at soup kitchens, homeless shelters, and through a network of community contacts. HOT functions by taking clinical services into the community and offering supportive interventions. Its success is reflected in numbers of persons housed, psychiatrically stabilized, and participating in rehabilitative services. Several clinical vignettes illustrate HOT's work.

1991

Barrow SM; Hellman F; Lovell AM; Plapinger JD; Struening EL. **Evaluating outreach services: lessons from a study of five programs.** In Cohen N (ed.), *Psychiatric Outreach to the Mentally Ill (New Directions for Mental Health Services)*, 52:29-45, San Francisco: Jossey-Bass, 1991.

This chapter describes an attempt by researchers to systematically evaluate a number of innovative service programs for homeless people with mental illnesses in New York City. The study was intended to describe the population reached and served by different types of outreach programs; to document the services each program delivered; and to compare the relative effectiveness of distinct program models by following samples of clients receiving intensive services from each program over a period of six months. However, as the target population expanded and the resources available to homeless individuals shifted, the programs in the study responded with changes in services. These changes led the researchers to refocus their efforts on a more process-oriented understanding of how the form, content, and combination of service elements affected the outcomes of interest.

Cohen NL; Tsemberis S. **Emergency psychiatric intervention on the street.** In Cohen N (ed.), *Psychiatric Outreach to the Mentally Ill. New Directions for Mental Health Services* 50: 3-16. San Francisco: Jossey-Bass, Inc., 1991.

Emergency psychiatric evaluation on the street with access to hospital-based medical or psychiatric services is described as effective in bringing many of the most disaffiliated homeless mentally ill persons back into the mental health and social service systems. The author describes the assessment process and the engagement process, and emphasizes the need for flexibility in outreach. The Homeless Emergency Liaison Project (Project HELP) in New York City is presented as a case study.

Engstrom K; Brooks EB; Jonikas JA; Cook JA; Witheridge TF. **Creating community linkages: a guide to assertive outreach for homeless persons with severe mental illness.** Chicago, IL: Thresholds National Research and Training Center on Rehabilitation and Mental Illness, 1991.

This manual was designed to teach case managers assertive community outreach techniques for working with persons who have mental illnesses and are homeless. Topics addressed include: qualities needed in an outreach worker, features of mental illness, the Total Team Approach, community support systems, and cultural relevance in treatment. Also included is an annotated bibliography of homelessness and mental illness. AVAILABLE FROM: Thresholds National Research and Training Center on Rehabilitation and Mental Illness, 2001 N. Clybourn Ave., Suite 302, Chicago, IL 60614, (312) 348-5522.COST: $17.65.

Interagency Council on the Homeless. **Reaching out: a guide for service providers.** Washington, DC: Interagency Council on the Homeless, 1991.

This is a practical, hands-on guide designed to help service providers:(1) understand the characteristics and service needs of homeless persons who live in a wide range of public settings; (2) plan and administer a local outreach effort; and (3) explore innovative strategies to provide outreach and other needed

services. AVAILABLE FROM: National Resource Center on Homelessness and Mental Illness, Policy Research Associates, Inc., 262 Delaware Avenue, Delmar, NY, 12054, (800) 444-7415.

Levine RN; Dzubur V; Sparks V; Lane SR; Ruiz K; Freeman M. **The San Francisco AIDS outreach program to the homeless**. Int Conf AIDS, 7:394 (abstract no. W.D.4024), June 16-21, 1991.

OBJECTIVE: To provide comprehensive outpatient services to an HIV-infected inner city population suffering multiple additional diagnoses, including homelessness, IV drug use, and mental illness. METHODS: We have developed a multidisciplinary AIDS Outreach Program including medical, nursing, mental health and social services. A centrally located primary care clinic with two hospice affiliations, and in cooperation with the County Hospital, is supported by outreach services that are street-based, located in shelters for the homeless, and in hotels serving transients. RESULTS: In two years we have had medical contacts with 555 people cumulatively, with an average of 9.3 visits per patient. Forty-three percent of total patients availed themselves of psycho-social services. Ninety-four percent of clients are male, 6% are female (n=550). Seventy-seven percent of patients are identifiable as homeless (n=483), and 84% self-identify as IV drug users (n=383). Of 506 people with documented HIV seropositivity 71% are symptomatic and 21% have an AIDS diagnosis. Most recent CD4 counts revealed 33% of people with less than 200 cells/mm(3), 41% with 200-500, and 26% greater than 500 (n=447). Of those patients with CD4 less than 500, 83% have been prescribed AZT. Of those with CD4 less than 200, 81% have had some form of PCP prophylaxis. CONCLUSIONS: We have found that when services are provided in a respectful, flexible and culturally sensitive way, ongoing primary care for symptomatic HIV-infected people, with multiple catastrophic diagnoses including homelessness, is possible.

Morse G; Calsyn RJ; West L; Rosenberg P; MillerJ. **Mental health outreach to the homeless: conceptual and clinical considerations.** St. Louis, MO: State of Missouri Department of Mental Health, 1991.

This paper attempts to develop new knowledge about outreach in the hopes of improving service effectiveness for homeless people. Basic conceptual and definitional issues related to outreach are discussed as well as common and alternative approaches to outreach. The alternative approach presented includes a discussion of stages and techniques in engagement, clinical issues in outreach, and follow up service options. Given the importance of the topic and the paucity of information on the subject, this paper places particular emphasis on discussing service approaches and clinical issues.

Reuler JB. **Outreach health services for street youth**. J Adolesc Health, 12:561-6, November 1991.

A voluntary health agency operated a clinic at a drop-in center for street youth. Six hundred nine youths were seen, with an average age of 16.75 years. There were 2,086 diagnoses made during 1,895 visits. Respiratory, dermatologic, and gynecologic problems represented 56% of all diagnoses. Pregnancy tests accounted for 38% of all procedures, 50% of all medications dispensed were either oral antibiotics or decongestants, and 17% of the visits resulted in referrals. This chart review revealed that street youth seen at a drop-in center sought care for common medical problems. Problems related to substance abuse and sexually transmitted diseases were seen much less frequently than anticipated. Elements critical to the success of this clinic included its on-site location, hours of operation when teenagers were using other services, close working relationships between clinic and center staffs, the capability to perform a few simple laboratory procedures, and an on-site pharmacy.

Rosenheck R; Gallup P. **Involvement in an outreach and residential treatment program for homeless mentally ill veterans**. J Nerv Ment Dis, 179:750-4, December 1991.

Descriptive data derived from initial assessment interviews and from standardized three-month progress reports are presented on 1684 homeless, chronically mentally ill veterans who were contacted at nine sites in a national Department of Veterans Affairs outreach program. Levels of involvement in the program were modest, with only 16% of those screened having over 10 clinical contacts and 24% still involved after three months. Demographic and clinical characteristics were weakly associated with continued involvement, but those admitted to residential treatment were 5.4 times more likely to be involved in the program than those not admitted. Admission to residential treatment appears to be the strongest determinant of clinical engagement of the homeless mentally ill.

Taggart D; Schwarcz L; Lacouture, D. **Living on the streets in Morris County, NJ: a report from project HOMI.** Madison, NJ: Mental Health Association of Morris County, 1991.

This report presents findings from a 21-month study of Project HOMI's 7-day per week mobile outreach service in Morris County, NJ. Included are: (1) numbers and characteristics of Morris County's street homeless population; (2) the results of an intensive interview of 40 street homeless; (3) formal and informal linkages developed and utilized by Project HOMI; and (4) policy recommendations.

Witheridge TF. **The active ingredients of assertive outreach.** In Cohen N (ed.), *Psychiatric Outreach to the Mentally Ill. New Directions for Mental Health Services*, 52:47-64. San Francisco, CA: Jossey-Bass Inc., 1991.

This chapter discusses 12 principles that have guided the development of a large, inner-city, long-term assertive outreach program that serves clients who are at high risk for hospitalization and homelessness. These principles include: (1) targeting service delivery to those persons who need the most attention; (2) preventing hospitalization and homelessness; (3) maintaining a high enough staff-to-member ratio to permit the direct provision of most services; (4) concentrating on improving the quality of people's everyday lives; (5) taking ultimate professional responsibility for the well-being of its members; (6) providing assertive advocacy on the members' behalf; (7) preventing the emergence of crises and managing unavoidable crises outside of the hospital; (8) most of the program's face-to-face interventions occur in the homes or neighborhoods of the members, not in the offices or facilities of the staff; (9) making heavy use of staff teamwork, de-emphasizing the use of individual caseloads, (10) involving its members in all aspects of the community support process; (11) involving families in all aspects of the community support process; and (12) offering its services on a time-unlimited basis.

1990

Cohen NL. **Stigma is in the eye of the beholder: a hospital outreach program for treating homeless mentally ill people**. Bull Menninger Clin, 54:255-8, Spring 1990.

Homeless mentally ill people, particularly in large urban centers, are one of the most stigmatized groups

in American society. The author describes a specialized short-term hospital treatment program initiated by New York City that helped reduce stigmatization by medical personnel. He suggests that training staff workers and increased government commitment to inpatient programs with outreach capacity can foster a change in attitude among treaters, thereby improving treatment outcome of the homeless mentally ill.

Ridlen S; Asamoah Y; Edwards HG; Zimmer R. **Outreach and engagement for homeless women at risk of alcoholism.** Alcoholism Treatment Quarterly 7(1):99-109, 1990.

This article describes an NIAAA-funded Demonstration Project for homeless women with alcohol problems in New York City. The Project is designed to provide outreach, engagement, and support services to a population of homeless females, mostly Black and Hispanic, who live in two Manhattan hotels for homeless families. Specifically, the project offers assistance with immediate needs, and provides referrals, follow-up and advocacy. Services include: acupuncture, employment assistance, housing relocation, GED/literacy, respite child care and alcoholism treatment services.

Scharer LK; Stuart,I; Lindsey A; Pitaro M; Zeeman B; Hennessey M; Pelofsky B; Smithwick G. **Education and training.** In Brickner PW; Scharer LK; Conanan BA; Savarese M; Scanlan BC (eds.), *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York, NY: W. W. Norton & Company, 1990.

According to the authors, traditional medical education's preferred teaching site is the inpatient facility, providing acute care. They contend that recent changes to teaching ambulatory care in clinic settings still does not ensure contact with homeless and poor persons. This chapter considers the current climate of medical and nursing education with respect to outreach and interdisciplinary care, notes the experiences of students placed at work sites, and provides examples of and guidelines for educational initiatives for health care professionals and patients.

Thompson PI; Jones TS. **Monitoring and documenting community-based organization outreach activities for populations at risk for HIV.** Hygie, 9(4): 34-38, December 1990.

Street outreach has been demonstrated to be an effective strategy for reaching persons who are not served by traditional health care programs and are at high risk for contracting the human immunodeficiency virus (HIV) and subsequent acquired immune deficiency syndrome (AIDS). The U.S. Centers for Disease Control (CDC) supports street outreach programs through a number of mechanisms that offer funding and technical assistance to State and local health departments, community-based organizations, and national organizations. A recent systematic review of four outreach programs and reviews of other CDC-supported outreach revealed the need for guidance concerning systems of monitoring and documenting services.

Wobido SL; Frank T; Merritt B; Orlin S; Prisco L; Rosnow M; Sonde D. **Outreach.** In Brickner PW; Scharer LK; Conanan BA; Savarese M; Scanlan BC (eds.), *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York, NY: W. W. Norton & Company, 1990.

This chapter describes the principles of outreach to people who are homeless and mentally ill and the qualities of an outreach worker. Examples of outreach from the Nashville, Milwaukee, Philadelphia, and San Antonio Health Care for the Homeless Projects are presented. The authors briefly discuss the challenges of evaluating outreach programs.

Undated

Fisk D; Rowe M; Brooks R; Gildersleeve D. **Integrating consumer staff into a homeless outreach project: critical issues and strategies.** In press, Psychiatric Rehabilitation Journal.

In this article, clinical and consumer staff describe their experiences employing formerly homeless persons with mental illness and/or substance abuse disorders on a federally funded homeless outreach team. The authors identify three challenging issues that emerged: 1) disclosure of consumer status; 2) client-staff boundaries; and 3) workplace discrimination. Three strategies are proposed to ease the integration of consumer staff into their work positions in clinical projects: 1) education and training of non-consumer staff; 2) individual supervision; and 3) distinguishing between when it is necessary to make reasonable accommodations for consumers from when their work responsibilities need to be modified.

Mullins SD. **Steps out: a peer-integrated outreach and treatment model for homeless persons with co-occurring disorders.** Rockville, MD: Substance Abuse and Mental Health Services Administration, undated.

This manual describes a peer-based treatment initiative designed to assist homeless individuals who suffer from both substance abuse disorders and co-occurring mental illness. The program's central philosophy is that outreach coordinated by staff who were once homeless is an effective means of linking program participants with prevocational and vocational opportunities. Topics discussed include: a conceptual framework; history and setting of the intervention; review of the literature; description of participant population; description of the intervention; case studies; and lessons learned.